



The Commonwealth of Massachusetts

Department of Industrial Accidents

600 Washington Street - 7th Floor, Boston, Massachusetts 02111
 Info.Line (800) 323-3249 ext: 470 in Mass. Outside Mass.- (617) 727-4900 ext. 470
<http://www.mass.gov/dia>

DIA Board #
(If Known):

Page 1 of 2

UTILIZATION REVIEW AGENT AND QUALITY ASSESSMENT PROGRAM COMPLAINT FORM

6.01: Scope and Authority: 452 CMR 6.0 *et seq.* is promulgated pursuant to M.G.L. ch. 152 §§5, 13 and §30 as most recently amended by St. 1991, c 398. 452 CMR 6.0 *et seq.* shall apply to all claims, irrespective of date of injury for health care services rendered on or after October 1, 1993. 452 CMR 6.0 *et seq.* requires workers' compensation insurers to undertake utilization review, sets forth the nature of utilization data that must be reported to the Department of Industrial Accidents, sets forth the methods for quality assessment that will be used by the Department of Industrial Accidents and sets forth the mechanisms that DIA will use to ensure compliance with 452 CMR 6.0 *et seq.*

Please check the appropriate box below: The UR Agent/Insurer has not:

- ☐ A. rendered an **Introductory Letter** that includes the rights and responsibilities of the employee and the UR Agent
- ☐ B. rendered a **Notice** of any kind to either the Employee or the Provider
- ☐ C. rendered a notice of **Adverse Determination** to both Employee and Provider [6.04(4)(b)]
- ☐ D. rendered a notice of Adverse Determination to both Employee and Provider within the **time constraints** [6.04(4)(b)]
- ☐ E. made its **Appeal-Level Determination** within the **time constraints** [6.04(4)(c)]
- ☐ F. provided a review by a **Same-School Practitioner** when rendering an appeal-level determination [6.04(4)(c)1]
- ☐ G. provided the **Review Criteria** used to make an adverse determination [6.04(4)(c)]
- ☐ H. provided all the **Reasons** used to reach an adverse determination [6.04(4)(c)]
- ☐ I. provided the Employee with a notice of **Rights and Responsibilities** and **Appeal procedure** [6.04(2)(d)]
- ☐ J. complied with **Telephone Requirements** for UR Agent availability and staffing [6.04(4)(d)]
- ☐ K. contracted with an approved agent to provide UR or to develop their own UR review program approved by the DIA to review both outpatient and inpatient health care services approved through the DIA [6.04]
- ☐ L. other: _____

TO FILE A COMPLAINT, PLEASE PROVIDE THE FOLLOWING INFORMATION:

TODAY'S DATE: _____

NAME OF PERSON FILING COMPLAINT: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

TEL: (____) _____

YOU ARE: (Please Check One):

☐ PROVIDER ☐ EMPLOYER ☐ EMPLOYEE ☐ OTHER

PLEASE NOTE: You are required to inform the injured employee of this filing. The injured employee will be cross-copied on all responses and exhibits received during the course of the complaint investigation

INJURED EMPLOYEE'S NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____ TEL: (____) _____

Page 2 of 2

ADDRESS: _____ ADDRESS: _____

CITY/STATE/ZIP: _____ CITY/STATE/ZIP: _____

NAME OF UR COMPANY: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE: (____)_____ DATE(S) OF CONTACT: _____

Using the following space, **summarize your complaint** about the UR Agent. In addition, attach copies of any other documentation to this form that supports your complaint, including correspondence from the UR Agent, specific dates of contact with the UR Agent, person(s) contacted, etc.:

SEND THIS COMPLETED COMPLAINT FORM WITH ATTACHMENT(S) TO:

**Department Of Industrial Accidents
Office of Health Policy
600 Washington Street, 7th Floor
Boston, Ma 02111**

A COPY OF THIS COMPLAINT AND ALL ATTACHMENTS WILL BE FORWARDED TO THE UR AGENT.